



Managing ADHD Children without Medication Individual, Family, Multi-Family and Larger Systems Interventions

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Malmo

Marlborough Family Service (MFS)

- combines Child and Adolescent Mental Health Service with Adult Psychotherapy Service
- for Westminster residents of any age, accessed via local referring agencies
- SLAs with Social Services and Education
- provides specialist services for individuals, families and professionals in the Greater London area, Home Counties and nationally

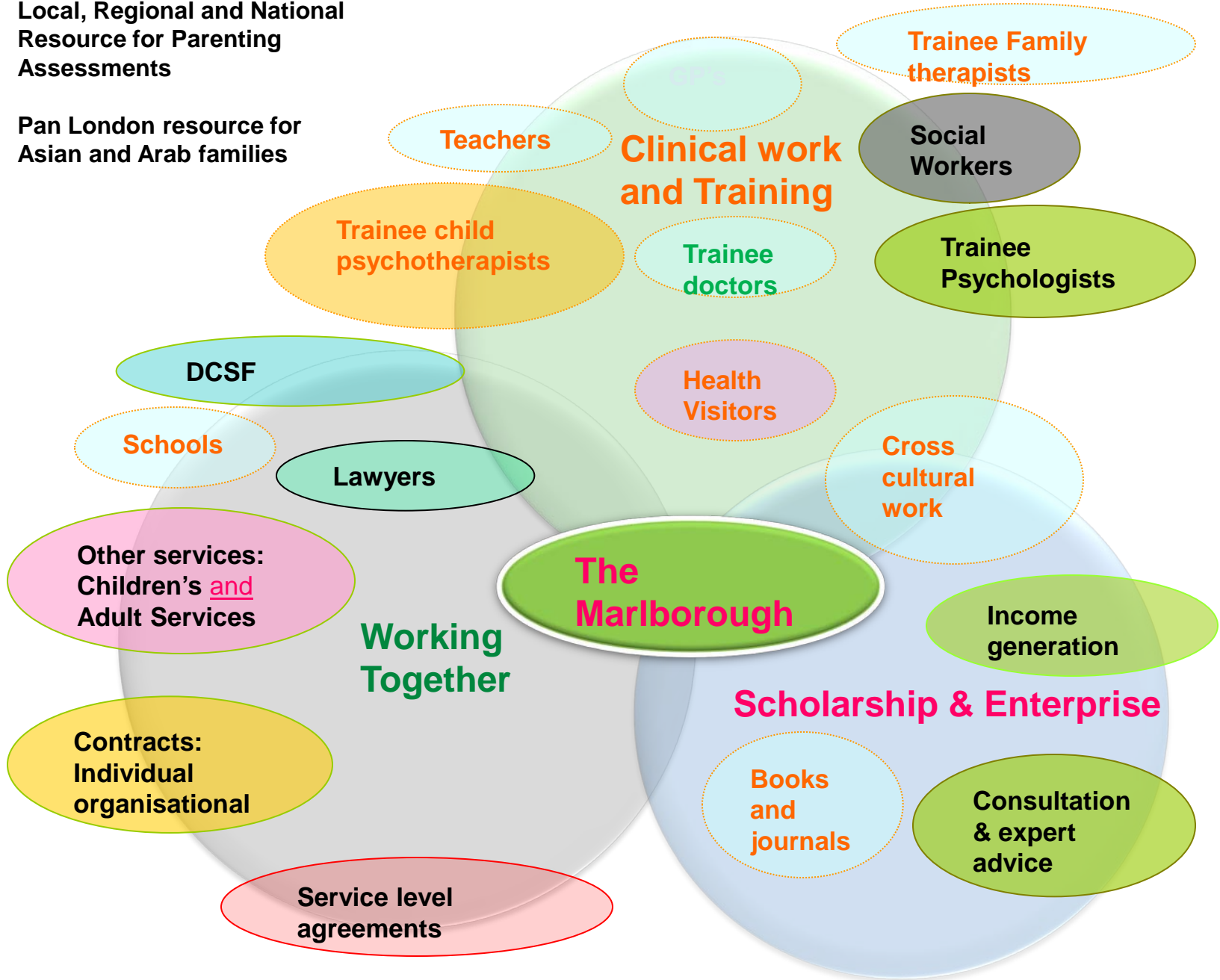
Marlborough Family Service (MFS)

- Each year 900 – 1000 new referrals, about 200 children per year referred for ? ADHD
- In addition many ongoing high complexity long-term cases
- No waiting list
- more than 40 professionals (p/t and f/t, incl. honorary contracts), from different disciplines and professional and cultural backgrounds

Domains of the Marlborough's work

Local, Regional and National
Resource for Parenting
Assessments

Pan London resource for
Asian and Arab families



Contextual Approach

“What are the contexts that we need to use or make to address the problems / issues?”

Person *who?*

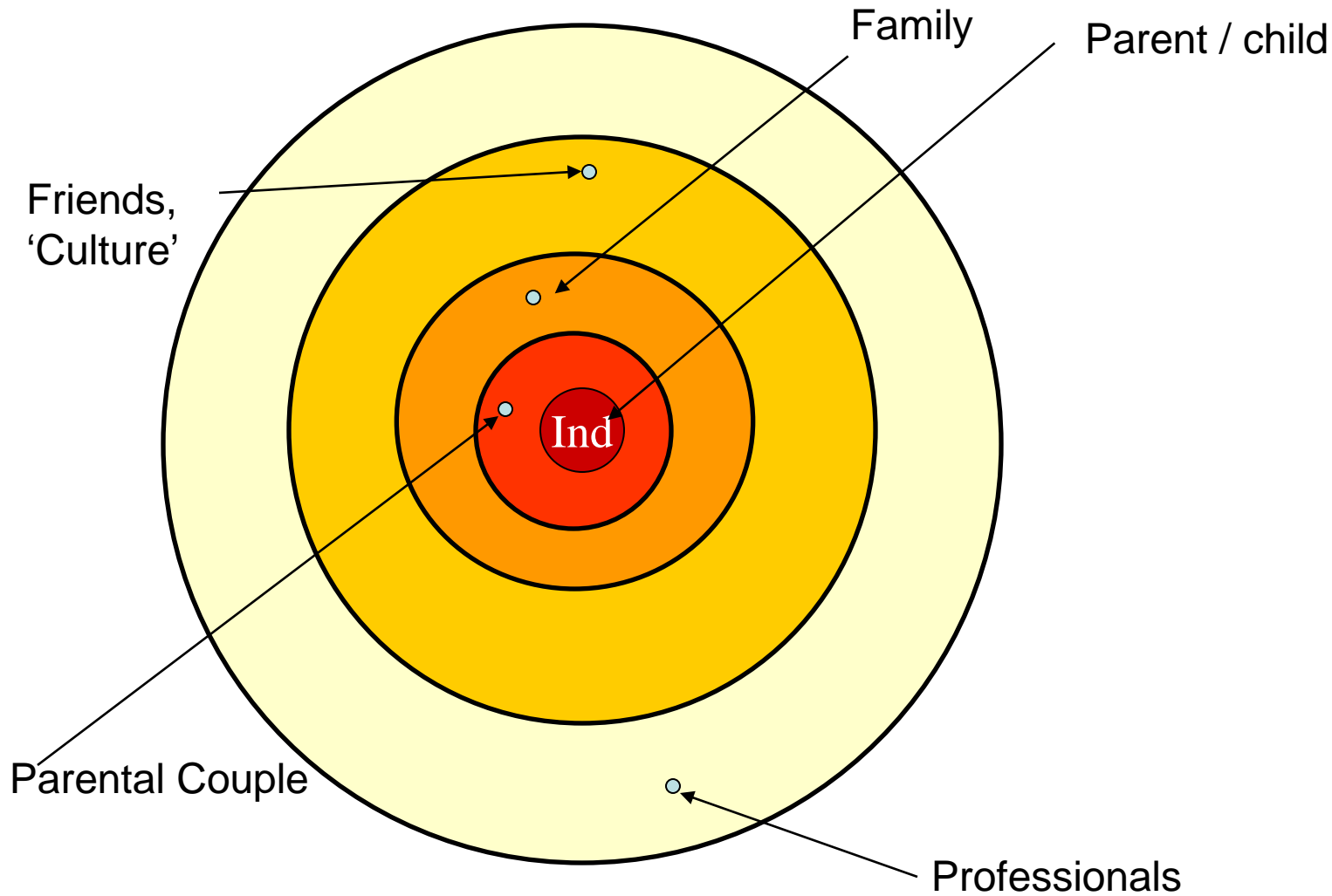
Time *when, how often, how long?*

Place *where?*

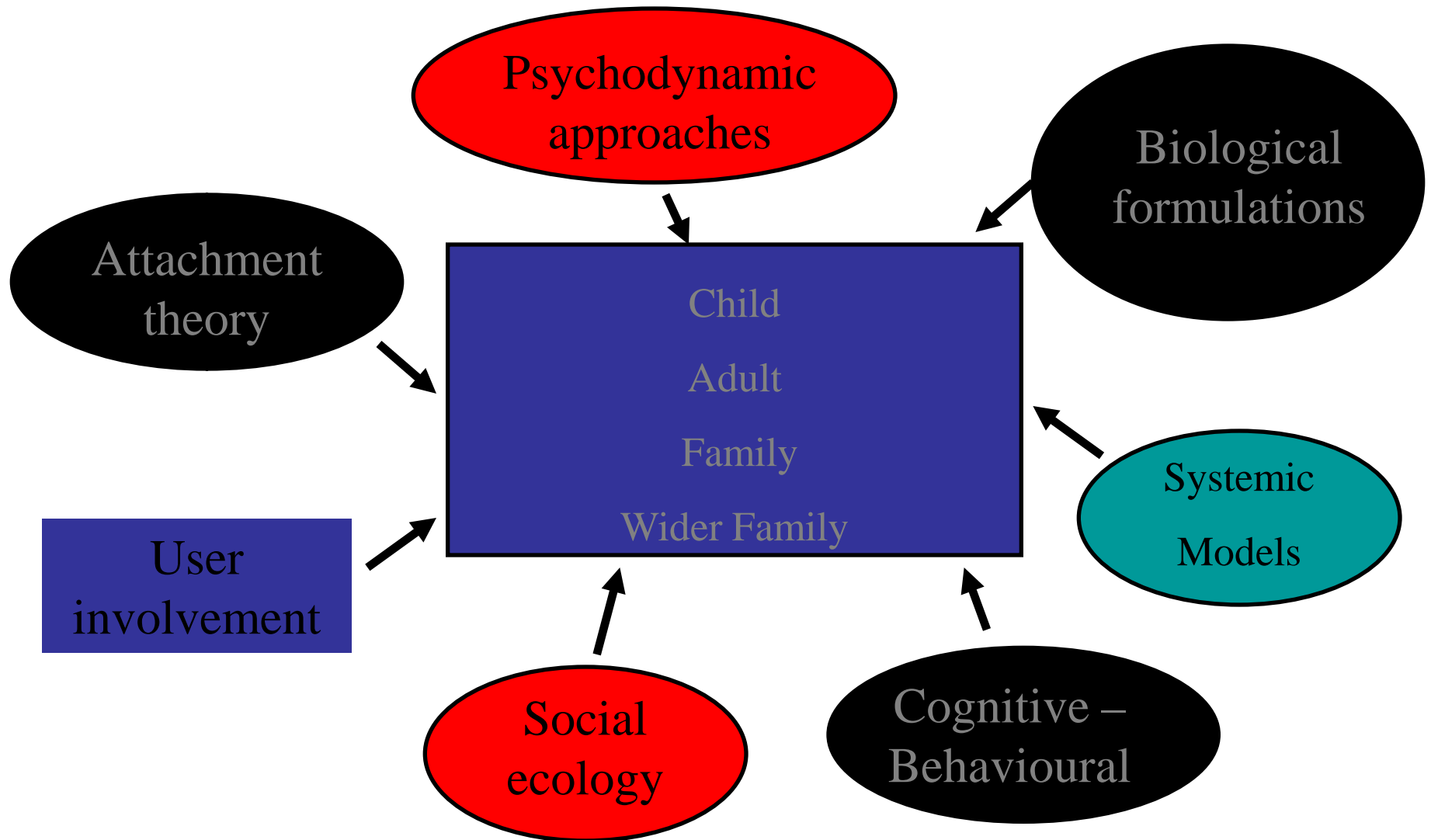
Activity *what?*

Modality *how?*

Levels of context for intervention



Multimodal Concepts and Interventions



ADHD - Definition

Heterogenous behavioural syndrome with:
inattention (6 or more specific symptoms, max 9)

hyperactivity

(6 or more specific symptoms, max 9)

impulsivity

with at least a moderate degree of psychological, social and / or educational / occupational impairment in multiple settings for at least 6 months, present before age 7

Inattention – symptoms (DSMIV)

No close attention to detail, careless mistakes

Difficulty sustaining attention

Not listening when spoken to

Not following through with instructions

Difficulty organizing tasks and activities

Not sustaining mental efforts

Losing things and assignments

Easily distracted

Forgetful

Hyperactivity and Impulsivity

Often fidgets / squirms

Leaves seat in classroom

Runs about and climbs excessively

Difficulty playing and leisure activities

'on the go', 'driven by a motor'

Talks excessively

Blurts out answers before questions completed

Difficulty awaiting turn

Interrupts or intrudes on others

ADHD: The Controversies

- No medical tests
- Non-specific symptoms overlap with normal children
- Arbitrary cut-off point
- Use of questionnaires and rating scales.
- High co-morbidity
- Lack of credible evidence of brain pathology
- Boys / externalising
- Limited cross-cultural applicability
- Non-specific genetics
- Philosophical ambiguity: circular reasoning.

Stimulants: The Controversies

- Non-specific treatment.
- **Side effects** frequent and problematic:
 - height, weight
 - cardiac function, blood pressure
 - reproductive system and sexual function
 - seizures and tics
 - psychotic and anxiety symptoms
 - irritability, agitation, suicidal thinking and self harm
 - drug misuse, addiction
 - liver damage
- **No evidence of long-term benefit.** MTA studies.
- **Social effects:** medicalisation, change ideas on 'childhood', disempowerment

National Institute Clinical Excellence (NICE) guideline 72

- Published September 2008.
- Concluded both childhood and adulthood ADHD were 'valid'.
- 'mild' and 'moderate' ADHD in children and adolescents psychosocial treatments should be the 'first line' treatments
- medication (mainly stimulants) as first line for those with more 'severe' ADHD
- Stimulants were also recommended as the first line treatment for adult ADHD.



Questioning 'Hyperactivity'

Who or what is 'hyperactive'?

Who says so?

What are the contexts within which
ADHD happens?

How can we manage and prevent
'hyperactivity' interactions?

Which intervention(s) should be made with
whom, where and at what point?

Separating the child from the problem

- “It’s this behaviour (name it) I don’t like, not you.”
- Can give the behaviour a name (e.g. Mr Temper, Bob, red mist)
- Personify the behaviour, give ‘Bob’ a character
- Group strategies to combat ‘Bob’
- Enlist helpers
- Notice exceptions
- Gives common ownership

Principles of managing 'ADHD' behaviours

Seeing child in multiple contexts

**Using naturalistic contexts in which 'live'
problems emerge or are 'enacted'**

Maintaining parental responsibility (*and control*)

**Focusing on intra-family resources and
strengths**

**Providing simultaneous multi-level
interventions**

Other lifestyle issues

- Family Time
- Fresh air and exercise
- Television and computer games
- Bedtime routines
- Responsibility, Trust and Independence
- Support

Individual Level Interventions

- Externalising techniques:
 - “the behaviour (name it) troubles me, not you”
- Give the behaviour a name (e.g. Mr Temper, Johnny, ‘Hyper’, red mist)
- Personify the behaviour, e.g. give ‘Johnny’ a personality
- Draw it, other visualisation techniques
- Practice being ‘hyper’ (20 min per day)
- Identify ways of stopping ‘him’ or ‘it’ (colour buttons or ‘breaks’)
- Focus on Exceptions
- Enact Hyperactivity, followed by self-calming strategies and reflective space
- Heart rate monitor work

Parental level Interventions

Inform parents and / or get them to inform themselves

Get parents to contextualise behaviour and look for fluctuations

Get parents to distinguish between 'angry' and 'hyper'

Get parents to consider 'time out' (for younger children) and 'withdrawal of privileges for older kids

Focus on strengths

Consistency and persistence – predict deterioration

Get parents to consider diets: balance, elimination of toxins, add supplements

(Remove artificial additives, colouring and preservatives. Consider lactose, salicylates and gluten. Add multi-vitamin and mineral and essential fatty acids high in EPA, low in DHA with evening primrose oil. Balance the diet- reduce sugar, salt, saturated fats, good breakfast, increase slow release carbohydrates and fibre)

Family Level Interventions

- Listening to family narrative rather than shaped narrative
- Participate in externalising strategies
- Family Time
- Improving the learning environment at home
- Fresh air and exercise
- Restrictions on TV and computer
- Bedtime and other routines
- Enactments
- Boundary making
- Document success(es)
- Dealing with those already labelled / on medication

Dietary interventions

- Remove artificial additives, colouring and preservatives. Consider lactose, salicylates, and gluten.
- Add multi-vitamin and mineral and essential fatty acids high in EPA, low in DHA with evening primrose oil.
- Balance the diet- reduce sugar, salt, saturated fats, good breakfast, increase slow release carbohydrates and fibre.

Social Context Interventions

- Working with school to close the home/school loop
- Social skills training
- If necessary change schools
- Create/join support groups
- Discuss in group setting what is 'ADHD' and what 'ALBD'

Working with schools

- Improving the learning environment at home
- Get the right assessment and help
- Working with school to close the home/school loop
- Teaching your child social skills
- If necessary change schools

Multi-Problem Families

Simultaneous presentation of number of problems:

- a) physical, sexual and emotional abuse and neglect
- b) chronic mental health issues
- c) social exclusion and social problems, such as poverty, unemployment, discrimination, inadequate housing
- d) alcohol and substance misuse
- e) violence, delinquency
- f) educational failure

Consequences

- Families difficult to reach, hard to treat
- Families and professionals full of mutual mistrust, denial, hostility and secrecy
- Families blame Social Services or 'system' for their problems, resistant to 'change', feel coerced to attend assessment or therapy
- Increasing numbers of professionals, with multiple opinions and splitting
- Professional paralysis

High Risk Children

Common presentations:

- Poor peer relationships
- Bullying and bullied
- Learning difficulties
- ADHD and ‘Hyperactivity’
- Depression and aggression (*opp.def.dis.*)
- Social and educational exclusion

Reasons for Intensive Multi-Family Work

- to connect families across cultures
- to overcome isolation and stigmatisation
- to compare experiences, 'mirrored' in others
- to create multiple new perspectives
- to move from 'helpless' to 'helpful'
- to experiment with cross-'fostering' and
'surrogate' parenting (cross-family linkage)
- to explore complex issues in a group setting
- to establish social community connections

Families as 'Consultants' or 'Buddies' to other Families

Families observe, comment and consult on 'good' and 'unhelpful' interactions and behaviours they see in each other- using examples from their own cultures of origin

Families create a network of support for isolated families, both inside and outside of family group work

'Graduate' families emerge and they engage new and sceptical families (*'ambassadors' and 'buddies'*), offering hope

Biofeedback heart rate monitoring

- Objective measurements enable the detection and monitoring of internal bodily functions with great sensitivity and precision
- Insight into the scope and limits of self-regulation of the body and associated mental states
- Individuals may experience them as providing a kind of sixth sense, or an extra window into their bodies and minds.



How it works

Families taught to recognise escalating stress:

Child and parent taught how to wear monitor. Heart rate monitor set to deliver audible beep at just below loss of control threshold.

Child and parent taught self calming strategies:

Individually, in the family and in the multi family contexts.

Families practise strategies:

Monitor worn for a full day, in Centre, in school and at home. Monitor gives wearer early notice of physical changes related to anger, stress or loss of control.

Print out of heart rate variation graph provides focus for discussion about triggers for stress and contexts where risk is high